U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 10 July 2007

In the Matter of:
C.Y.[1], Widow of P.Y.
Claimant

v. Case No.: 2006-BLA-06038

GARDEN CREEK POCAHONTAS CO.
Employer
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:
Ms. Sparkle Bonds, Esq.
For the Claimant

Ms. Kathy Snyder, Esq.
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER

Award of Benefits

This matter arises from a claim for survivor's benefits filed by Ms. C.Y., widow of Mr. P.Y (miner) for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who die due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

PROCEDURAL HISTORY

The miner filed an application for benefits on November 11, 1995. A Decision and Order awarding benefits was issued by Administrative Law Judge ("ALJ") Daniel Sutton in 2003 and

[1] Effective August 1, 2006, the Department of Labor instituted a policy that decisions and orders in cases under the Black Lung Benefits Act which will be available on this Office's website shall not contain the claimant's name. Instead, the claimant's initials will be used.

affirmed by the Benefits Review Board ("BRB"). The miner was able to establish legal pneumoconiosis, but not clinical pneumoconiosis. The Employer did not appeal the decision of the BRB.

On March 15, 2005, the miner died. The miner's spouse filed for survivor's benefits on April 19, 2005. The District Director issued a proposed Decision and Order awarding benefits on May 3, 2006. On May 9, 2006, the Employer timely filed a notice contesting the Decision and sought a formal hearing. The Claimant requested that a decision be issued on the record and waived the right to a hearing. A telephone hearing was held on May 11, 2007. For purposes of identification, I admitted exhibits DX1 – DX31, EX1 – EX12, CX1, along with twelve (12) new exhibits not previously in the living miner's claim. The parties were given a two week extension of time to file closing arguments.

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at part 718 apply. This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Virginia within the territorial jurisdiction of that court. ***Shupe v. Director,* OWCP**, 12 B.L.R. 1-200 (1989) (en banc).

This case represents a survivor's claim for benefits. In order to receive benefits, the claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). A miner's death was due to pneumoconiosis if: (1) competent medical evidence establishes that the miner's death was due to pneumoconiosis, (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis, or (3) the presumption for complicated pneumoconiosis at § 718.304 is applicable. 20 C.F.R § 718.205(c)(1) – (3). However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4).

A "substantially contributing cause" is any condition that hastens the miner's death. 20 C.F.R. § 718.205(c)(5). Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. In a survivor's claim under Part 718, the claimant must demonstrate that pneumoconiosis "hastened" the miner's death "in any way.", ***Richardson v. Director, OWCP***, 94 F.3d 164 (4th Cir. 1996);***Shuff v. Cedar Coal Co***., 967 F.2d 977 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 969 (1993).

STIPULATIONS AND WITHDRAWAL OF ISSUES

1. The Employer stipulated to thirty five (35) years of coal mine employment.
2. The person upon whose death or disability the claim is based is a miner.
3. The Claimant is a widow of the miner and a dependant of the miner, thus qualifying as a survivor.
4. The Claimant is an eligible survivor.
5. The Employer is the responsible operator.
6. The miner worked as a miner after December 31, 1969.
7. The miner's most recent period of cumulative employment of not less than one year was with the named responsible operator.

I have reviewed all of the evidence in the record and I accept the stipulations as they are consistent with the evidence.

ISSUES[2]

1. Whether the miner had pneumoconiosis.
2. If so, whether pneumoconiosis arose out of coal mine employment.
3. Whether the miner's death was due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[3] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[4] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[5]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production; the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

---

[2] The Employer objects to the implementation of the new regulations as contrary to principles of due process. The issue is not discussed in this Decision since it is not relevant. However, the Employer's objections are noted and preserved for appellate purposes.

[3] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, ant hearing held under this chapter shall be conducted in accordance with [the APA]; 5 U.S.C. § 554(c)(2). Longshore and Harbors Workers' Compensation Act ("LHWCA") 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[4] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director***, OWCP [Sainz], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[5] Also known as the risk of non-persuasion, *see* 9 J. Wigmore, Evidence § 2486 (J. Chadbourn rev. 1981).

MEDICAL EVIDENCE[6]

The following is a summary of the evidentiary record designated for consideration.

Chest X-Ray[7]

Date of X-Ray	Date of Reading	EXH.	Physician	Interpretation
09/05/2004	09/26/2006	EX1	Dr. Wheeler B-BCR	FQ 2; Negative for pneumoconiosis. Linear discoid atelectasis or scar in right mid lung.
09/05/2004	09/26/2006	EX2	Dr. Scott B-BCR	FQ 2; Minimal discord atelactasis or linear scar right mid-lung, left lower lung.

Pulmonary Function Studies

Exhibit	Date	Age	HT	FEV1	FVC	MVV	FVC/FEV1	Qualify
EX6	04/26/90	61	65"	2.67* 3.08	1.51* 1.71	44* 57	56%* 55%	----------
EX8	02/29/88	-----	------	------		------	------	Test read for validation purposes only. Invalid Test

*Post-bronchodilator

Arterial Blood Gas Studies

EXH	Date	Physician/Facility	PO2	PCO2
EX7	02/16/87	**Dr. McVey**	68	39
DX10	08/10/03	**Clinch Valley**	83.7	41.5
DX10	09/01/04	**Clinch Valley**	69.6	39.6
EX9	08/05/88	**Humana Hospital**	72	34

Medical Reports

Date of Exam	Physician/Facility	EXH.
03/05/2007	**Dr. McVey**	CX1

Dr. McVey submits a brief letter stating that he was the miner's treating physician for over 20 years prior to the miner's death on March 15, 2005. Dr. McVey had treated the miner numerous times for chronic obstructive pulmonary disease, exacerbation, asthmatic bronchitis, severe pulmonary emphysema, and coal workers' pneumoconiosis. The miner was also hospitalized

[6] The Employer objects to the evidentiary limitations imposed by the amended regulations. Any evidence submitted in excess of the limitations on evidence is marked for identification. These exhibits have been marked for identification and admitted into the record; however, they will not be considered for evaluation in the adjudication of this present claim. The objection to the implementation of the amended regulations has been noted and the issue has been preserved for appellate purposes.

[7] Claimant's Counsel, when asked to designate x-rays for consideration of instant claim, referred generally to the list of numerous portable chest x-rays and CT scans that were taken at Clinch Valley Medical Center and submitted by Dr. McVey along with his report. CT scans are considered "other" evidence and

numerous times for COPD, coal workers' pneumoconiosis, and acute spontaneous pneumothorax of the left lung. The miner worked in or around coal mines for approximately 38 years. It is Dr. McVey's opinion that the miner's death was hastened by coal workers' pneumoconiosis.

02/20/2007 **Dr. Ghia** EX4

The miner had a history of chronic obstructive pulmonary disease (COPD) complicated by both chronic respiratory failure and recurrent pneumothoraces; he required oxygen supplementation 24 hours a day; this is described as severe, advanced, and end-stage. Rather than COPD after coal dust exposure, the miner has the classic presentation of COPD after smoking cigarettes. The miner's respiratory failure and recurrent pneumothoraces are clearly associated with his COPD following smoking. COPD from coal dust exposure and from smoking are very different. Various studies indicate and support the proposition that coal dust induced COPD is characterized by the following:

- Small reduction in FEV1 can be noted with increasing tenure in miners and cumulative dust exposure.
- Similar trend can be found with FVC.
- Airflows can decrease with increasing years underground.
- Declines in FEV1/FVC have been shown to follow increasing dust exposure.

Dr. Ghia cites several studies for the following propositions: (1) "[i]t appears almost impossible for the losses in pulmonary function described in the literature as attributable to coal dust exposure to ever be of clinical significance." (2) "If the inhalation of coal dust in the absence of smoking and complicated CWP ever induces sufficient ventilatory impairment to preclude a miner from working, it is indeed rare", and (3) "in the absence of cigarette smoking, long-term underground coal mining does not result in significant impairment of pulmonary function." Therefore, the miner's respiratory failure cannot be attributed to his coal dust exposure. The miner's symptoms, findings on lung examination, hypoxemia on blood-gas studies, and x-rays all support diagnosis of COPD following cigarette smoking rather than coal dust exposure. His death was the result of respiratory failure and this was associated with his COPD after cigarette smoking and not associated with any lung injury after coal dust exposure. Coal workers' pneumoconiosis or coal mine dust exposure did not cause or hasten the miner's death.

04/12/2007 **Dr. Hippensteel** EX12
(deposition)

Dr. Hippensteel reviewed several medical records upon which he based his findings and conclusions. The records include, but are not limited to, the following: operative record by Dr. Hobelheinrich, from June 16, 2003, a chest x-ray film dated June 16, 2003 by Dr. Hallo, artierial blood-gases from August 10, 2003, a consultation report by Dr. Iosif on September 29, 2003, a discharge summary of the miner's hospital stay from September 28, 2003 by Dr. McVey, consultation report from January 28, 2004 by Dr. Kadel, a chest CT scan interpreted by Dr. Scatarige on January 29, 2004 Additional x-ray readings were reviewed: January 30, 2004 x-ray, a February 7, 2004 film, and also films from February 8, 9, 10, and 11, 2004. Dr. Hippensteel also reviewed x-ray interpretations by Dr. Hallo from January 30, 2004, a February 1, 2004 film, a February 11, and 12, 2004 film. He also reviewed chest films by Dr. Dwyer on February 3 and February 5, 2004.

He also reviewed a history and physical done by Dr. Karbaria on September 2, 2004, as well as arterial blood gases on September 2, 2004 and he also reviewed interpretations from September 5, 2004. Dr. Hippensteel reviewed summary of hospitalization from September 1, 2004 through September 6, 2004. He reviewed an endocrinology interpretation from February 14, 2005. Dr. Hippensteel also reviewed a death certificate signed by Dr. McVey on March 22, 2005 as well as a chest CT scan from Clinch Valley Medical Center.

Dr. Hippensteel states that the death certificate makes no mention of the miner's smoking history or bullous emphysema, which is unrelated to coal workers' pneumoconiosis. The medical record makes no mention of coal workers' pneumoconiosis. In June 1988, the medical records make specific mention of COPD and coal workers' pneumoconiosis. In all of his hospitalization reports, there is only one mention of pneumoconiosis. Dr. Hippensteel also reviewed chest x-ray interpretation by Dr. Patel of September 1, 1992, and April 8, 1994, April 9, 1998, arterial blood gas studies of April 9, 1998, a chest x-ray reading from Dr. Hallo, and x-ray interpretations by Dr. McLane of x-rays taken on June 20-2003, June 22, June 23, 2007, and June 24, 2007. A CT scan read by Dr. Devanath on June 25, 2003. The miner was thought to have diffuse emphysema, but no mention made of the miner's chest x-rays or CT scans of any evidence of coal workers' pneumoconiosis. On September 8, 2003 Dr. McVey concluded the miner had large density in lung. Dr. Hippensteel states that Dr. McVey's conclusion of end-stage asthmatic bronchitis is only an add-on. Dr. Scatarige does not support it with information otherwise in these records. Dr. McVey's diagnosis is not properly correlated with the information in the medical record. The hospitalizations are not related to his coal workers' pneumoconiosis, they are related to his asthmatic bronchitis which is associated with his COPD.

The post-bronchodilator studies appear to be valid and showing significant reversibility, and on those studies he showed he had no restrictive disease as one would expect as a result of coal workers' pneumoconiosis. The miner had asthmatic bronchitis which is associated with reversibility.

All of these findings put together, even with a finding of pneumoconiosis, his problems were from diseases separate from that pneumoconiosis that led to his recurrent hospitalization and recurrent pneumothoraces and finally to his death. He has pneumonia associated with bullous emphysema, aggravated by cigarette smoking, and his asthmatic bronchitis, which Doctor McVey reported was end stage. In Dr. Hippensteel's opinion, the miner's death would have occurred at the same time, whether he had pneumoconiosis or not. These independent problems that he had were the cause of his demise and would have occurred at the same time had he not developed coal workers' pneumoconiosis as an additional diagnosis.

04/26/2007 **Dr. Ghia** EX11
(deposition)

Dr. Ghia formed his medical opinion and conclusions regarding the presence or absence of pneumoconiosis by reviewing the medical evidence provided to him from the miner's record. Dr. Ghia did not examine the miner. He opinion and conclusion is premised upon the miner's employment history, smoking history, survivor's form for benefits, description of work, and records from Clinch Valley Medical center. Dr. Ghia also reviewed a 1990 pulmonary function test provided by Dr. Bircher. The pulmonary tests demonstrate a moderate obstruction with a detriment to diffusing capacity and this is consistent with COPD following cigarette smoking. The miner had a significant history of exposure to coal mine dust and also was a heavy smoker.

There is a history of severe COPD, also labeled as advanced and end-stage. It was complicated by numerous exacerbations requiring hospitalizations. CT scan showed significant destruction of the lung with bullous formation; very common with cigarette smoking. The damage is also called emphysema. There were no pleural abnormalities, no pneumoconiosis. Certainly there was no evidence of medical pneumoconiosis. There is no legal pneumoconiosis either. The likelihood of hypoxic respiratory failure with coal dust exposure is very rare.

Death Certificate

Date of Certificate	**Physician/Facility**	**EXH.**
03/15/2005	**Dr. McVey**	DX9

Immediate cause of death was acute and chronic respiratory failure with underlying coal workers' pneumoconiosis.

Hospitalization Records/Treatment Notes

Date of Exam	**Physician/Facility**	**EXH.**
02/07/1988	**Humana Hospital Clinch Valley Medical**	CX1

The miner was admitted by way of ER with acute pulmonary distress. He was very short of breath and having acute chest pain. The miner was admitted and started on IV thephylline. X-rays showed no acute disease in the chest. There was mild fibrotic scarring in the left lower lobe and this seemed to be stable.

04/09/1988	**Humana Hospital Clinch Valley Medical**	CX1

The miner was admitted on a STAT basis from the clinic to HHCV with IV going. He was extremely diaphoretic and showing obvious air hunger. Final diagnosis on discharge is acute asthmatic bronchitis, severe, with severe acidosis, acute myocardial ischemia, emphysema, COPD, history of alcoholism, status of post herniated nucleus pulposus surgery.

06/10/1988	**Clinch Valley Medical**	CX1

The miner was admitted by way of the ER, acute severe pulmonary distress, almost unconscious, severe acidosis. The patient was discharged with a final diagnosis of: acute asthmatic bronchitis, severe acidosis, CO2 retention and hypoxia, acute myocardial ischemic history, emphysema, acute anxiety, COPD with coal workers' pneumoconiosis, history of alcoholism, status post herniated nucleus pulposus surgery, hypertension controlled.

06/16/2003	**Clinch Valley Medical**	CX1

The miner was discharged from the hospital with a final diagnosis of COPD exacerbation with CWP and acute spontaneous pneumothorax of the left lung, status post thoracotomy tube was placed and then removed. The miner was initially admitted with complaint of increasing respiratory distress.

09/23/2003	**Clinch Valley Medical**	CX1

The miner presented himself to the emergency room complaining of shortness of breath and chest pain. Miner has history of COPD and CWP. Miner presented with severe respiratory distress that developed over a period of several days and became increasingly worse. Miner was felt to have pneumothorax. Miner was put on nebulized albuterol and atrovent solution and continued on Decadron.

Other Evidence

Date of Exam	**Physician/Facility**	**EXH.**
01/29/2004	**CT Scan**	CX1

Helical scans of the thorax were performed with intravenous contrast. Small amount of subcutaneous emphysema in the left mid to lower chest wall. Underlying changes of chronic lung disease with small peripheral emphysematous blebs in the paramediastinal regions.

06/25/2003	**CT Scan**	CX1

Note is made of marked diffuse pulmonary emphysema throughout both lungs. Numerous peripheral blebs are present along the peripheral aspect of left lower lobe.

Existence of Pneumoconiosis

In a survivor's claim filed after January 1, 1982, claimant must establish the existence of pneumoconiosis, when the existence of pneumoconiosis is an issue, under any of the methods available at Section 718.202(a)(1)-(4) before establishing death due to pneumoconiosis at 20 C.F.R. §718.205(c). ***Trumbo v. Reading Anthracite Co.***, 17 BLR 1-85 (1993). The presence of pneumoconiosis arising from coal mine employment was established in the living miner's claim. In the instant survivor's claim, the Employer has not stipulated to the presence of pneumoconiosis. This case arises within the territorial jurisdiction of the Fourth Circuit. Thus, absent contrary evidence, while evidence relevant to any of the above categories may demonstrate the existence of pneumoconiosis, the adjudicator, in the final analysis, must weigh all of the evidence together in reaching a finding as to whether a miner has established that he has pneumoconiosis. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203, 211, 22 B.L.R. 2-162 (4th Cir.2000). The initial question is whether the establishment of pneumoconiosis in the living miner's claim has preclusive effect in the instant claim and bars the Employer from relitigating the issue. For reasons discussed below, I conclude that the establishment of pneumoconiosis in the living miner's claim has preclusive effect in the instant survivor's claim and bars the Employer from relitigating the issue. Consequently, I need not engage in a ***Compton*** analysis in determining the existence of pneumoconiosis.

The presence of pneumoconiosis and causation was established in the living miner's claim. The Claimant now argues that the doctrine of offensive collateral estoppel bars the Employer from relitigating the issue of pneumoconiosis and causation. Collateral estoppel is a concept that refers to the fact that a particular question of fact or law, one that has already been fully litigated by the parties in an action for which there has been a judgment on the merits, cannot be relitigated in any future action involving the same parties or their privies (persons who would be bound by the judgment rendered for the party). The term issue preclusion is synonymous with collateral estoppel, a doctrine which bars the relitigation of the same issue that was the basis of a finding or verdict in an action by the same parties or their privies in subsequent lawsuits involving the same or different causes of action.

In support of its position on collateral estoppel, the Claimant cites ***Collins v. Pond Creek Mining, Inc.***, 468 F.3d 213 (4th Cir. 206). The application of the doctrine of collateral estoppel and its preclusive effect on the relitigation of issues in Black Lung claims is well established. In ***Collins v. Pond Creek***, the Fourth Circuit court of appeals upheld the Claimant's reliance on the establishment of pneumoconiosis in the living miner's claim in precluding the Employer from relitigating the issue in the subsequent survivor's claim. *See* ***Collins v. Pond Creek Mining Co.***, 468 F.3d 213 (4th Cir. 2006) (Shedd, CJ., dissenting)

Before the Claimant can bar the Employer from relitigating the issue of pneumoconiosis, the Claimant is obligated to establish five elements: (1) that the issue sought to be precluded is identical to one previously litigated, (2) that the issue was actually determined in the prior proceeding, (3) that the issue's determination was a critical and necessary part of the decision in the prior proceeding, (4) that the prior judgment is final and valid and, (5) that the party against whom collateral estoppel is asserted had a fair and full opportunity to litigate the issue in the previous forum. ***Sedlack v. Braswell Servs. Group, Inc.***, 134 F.3d 219, 244 (4th Cir. 1998) In 2003, Judge Sutton awarded benefits to the miner in the life claim after having determined that the miner had established the presence of legal pneumoconiosis and total disability due to pneumoconiosis. In this survivor's claim, the presence of pneumoconiosis, once again, is at issue; specifically legal pneumoconiosis. It is (1) evident that the issue sought to be precluded – legal pneumoconiosis - is identical to the one previously litigated before judge Sutton and that the (2) issue was actually determined and the miner was found to have established the presence of pneumoconiosis. Furthermore, the presence of pneumoconiosis was a (3) critical and necessary part of the decision since it was an element that had to be established prior to obtaining Black Lung benefits. Judge Sutton's ruling (4) was final and valid. Employer's Counsel; however, argues that the party against whom collateral estoppel is asserted, Garden Creek Pocohantas Coal Co., did not have a fair and full opportunity to litigate the issue of pneumoconiosis in the previous claim. Essentially, Employer's Counsel argues that thoracic CT scan technology was not widely available or routinely performed as part of federal Black Lung examinations when the miner's claim was litigated and; therefore, Garden Creek did not have a fair and full opportunity to litigate the issue based on the new technology.

The Employer's argument raises the question of whether it is equitable for a party, who has had issues of fact adjudicated adversely to it in an equitable action, to be collaterally estopped from relitigating the same issues in a subsequent legal action brought against it by a new party because new technology not widely available in the prior litigation precluded the losing party from fully and fairly litigating the issue. In reviewing the procedural history of this case and the evidence in the record, I conclude that the doctrine of collateral estoppel precludes the Employer from relitigating the issue of pneumoconiosis.

Allowing offensive collateral estoppel may be unfair if the Employer did not have an incentive to vigorously litigate the issue in the prior proceeding or procedural opportunities exist in the new proceeding that were not available in the prior proceeding. Collateral estoppel is also inapplicable where the burden of proof differs between the two proceedings. None of the circumstances that might justify preclusion of the use of collateral estoppel in this case is present. The Employer had a fair full opportunity to litigate the issues in the prior proceeding. The Employer's argument that new CT scan technology precluded it from fully litigating the issue in the previous proceeding misinterprets the basic purpose of the doctrine and the issue at hand. The basic purpose of issue preclusion beyond precise repetition of the first action is to prevent relitigation by mere introduction of cumulative evidence bearing on a simple historic fact that

has once been decided. Thus, a determination that the miner suffered from a condition sufficiently established as legal pneumoconiosis should not be denied preclusive effect because of new evidence in the form of CT scan technology evidence which *may* or *may not* establish pneumoconiosis. So much is common ground. Furthermore, x-ray and CT scan technology is not dispositive on the issue of either legal or clinical pneumoconiosis. It is merely "other," additional evidence which may be considered and evaluated when determining the presence of pneumoconiosis.

A claimant may establish the existence of legal pneumoconiosis "if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion." 20 C.F.R. § 718.202(a)(4). I find, alternatively, Judge Sutton determined that the miner had legal pneumoconiosis, and that CT scans are not relevant to a determination of legal pneumoconiosis. Legal pneumoconiosis is a much broader category of disease than medical pneumoconiosis, which is a particular disease of the lung generally characterized by certain opacities appearing on a chest x-ray. *See* ***Barber v. Director, OWCP***, 43 F.3d 899 (4th Cir. 1995); ***Dehue v. Director, OWCP***, 65 F.3d 1189 (4th Cir. 1995); ***Hobbs v. Clinchfield Coal Co.,*** 45 F.3d 819 (4th Cir. 1995) ("a medical diagnosis of no pneumoconiosis is not equivalent to a legal finding of no pneumoconiosis").

Having established all five elements, I must determine whether a "major" change in law since the prior Decision precludes application of the doctrine. The doctrine of collateral estoppel does not apply to a legal ruling if there has been a "major" change in the governing law since the prior adjudication that "could render [the] previous determination inconsistent with prevailing doctrine." *See* ***Montana v. United States***, 440 U.S. at 161 (citing ***Comm'r v. Sunnen***, 333 U.S. 591, 599 (1948)). The award of benefits in the living miner's claim was issued in 2003. In reviewing the applicable case law since 2003, I find the governing law to be unchanged and the doctrine of collateral estoppel applicable to the current claim. Consequently, I conclude that the Claimant in the instant claim may rely on the establishment of legal pneumoconiosis in the living miner's claim and bar the Employer from relitigating the issue. Among the evidence I have admitted are pulmonary function tests, arterial blood-gas studies, and x-ray interpretation; primarily used to substantiate and establish the presence of pneumoconiosis and total disability. Total disability is not an issue in a survivor's claim for benefits and the presence of pneumoconiosis was established in the living miner's claim. Because I have concluded that the Employer is barred from relitigating the issue of the presence of pneumoconiosis, I need not discuss the evidentiary record in the instant claim with regard to this issue. The sole remaining issue in this case; therefore, is whether the miner's death was due to pneumoconiosis.

Death Due to Pneumoconiosis

Section 718.205 provides that benefits are available to eligible survivors of a miner whose death was due to pneumoconiosis. An eligible survivor will be entitled to benefits if any of the following criteria are met:

1. Where competent medical evidence establishes that the miner's death was due to pneumoconiosis;
2. Where pneumoconiosis was a substantially contributing cause or factor

leading to the miner's death, or where death was caused by complications of pneumoconiosis; or

3. Where the presumption set forth in §718.304 (evidence of complicated pneumoconiosis) is applicable. 20 C.F.R. § 718.205(c). Pneumoconiosis is a substantially contributing cause of a miner's death if it hastens the miner's death. 20 C.F.R. §718.205(c)(5).

The circuit courts developed the "hastening death" standard, which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. Complicated pneumoconiosis is not applicable in this case, therefore, the presumption set forth in § 718.304 in not applicable.

Any condition that hastens the miner's death is a substantially contributing cause of death for purposes of §718.205***. Shuff,*** *supra*. Pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way. ***Richardson,*** *supra*.

Prior to discussing the issue of death due to pneumoconiosis, I note that a survivor's claim and the deceased miner's claim are separate claims and do not merge under 20 C.F.R. § 725.309(c) Claimant's Counsel was specifically asked whether evidence from the life claim was to be admitted and used in the instant survivor's claim and she responded by saying no. The Employer has not designated any evidence from the living miner's claim. Therefore, the evidence from the living miner's claim is not made a part of this record. (TR at 11)

A death certificate was issued and signed on March 17, 2005, by Dr. James McVey, the miner's treating physician. The death certificate requires the attending physician to list the conditions leading to the immediate cause of death. According to Dr. McVey, the miner died as a result of respiratory failure, with coalworkers' pneumoconiosis leading to the immediate cause of death.

A physician's conclusory statement on a death certificate, without further elaboration, is insufficient to meet Claimant's burden as to the cause of death. ***Bill Branch Coal Corp. v. Sparks***, 213 F.3d 186, 192 (4th Cir. 2000). The treating physician may be required to provide more than a conclusory statement before finding that pneumoconiosis contributed to the miner's death. It should be noted that a death certificate, in and of itself, is an unreliable report of the miner's condition and it is error to accept conclusions contained in such a certificate where the record provides no identification that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. ***Smith v. Camco Mining, Inc.***,13 B.L.R. 1-17 (1989); ***Addison v. Director, OWCP***, 11 B.L.R. 1-68 (1988).

Dr. McVey; however, had intimate knowledge of the miner's physical condition, having treated him continuously over a 20 year period. Dr. McVey's treatment of the miner over such a long period of time demonstrates that he has observed the miner for a sufficiently long period of time to be able to be able to obtain a superior understanding of the miner's condition. Dr. McVey has also treated the miner often enough to fully understand the miner's health issues. The evidence designated for evaluation consists of 10 separate dates of treatment notes from Dr. McVey over a 16 year period, ranging from September 1987 to June 2003. Dr. McVey treated the miner's condition of emphysema and COPD, both respiratory ailments included within the definition of legal pneumoconiosis. Therefore, after assessing these factors I conclude that Dr. McVey's opinion merits additional weight based on his status as the miner's treating physician

as well as the duration and nature of the physician-patient relationship between Dr. McVey and the miner. 20 C.F.R. §718.104(d). I do not attribute controlling weight to Dr. McVay's opinion because the Employer submitted contrary evidence.

The Employer submits rebuttal evidence in the form of two depositions; one of Dr. Ghia and the other of Dr. Hippensteel. The Employer also submits a medical report for consideration and evaluation prepared by Dr. Ghia.

In reviewing the testimony of Dr. Hippensteel, I find his conclusion and medical opinion are problematic. It is noted that 20 CFR § 725.458 provides that "[t]he testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of testimony contained in §725.457(d)." 20 C.F.R. §725.458 (2001). Furthermore, as previously indicated in this Decision, a survivor's claim and the deceased miner's claim are separate claims and do not merge under 20 C.F.R. § 725.309(c). Since Dr. Hippensteel's conclusion and findings are premised, in large part, upon a review of 1992, 1994, and 1998 x-ray interpretations, along with examination of 1998 blood-gas studies, this constitutes an impermissible consideration of evidence outside the scope of the evidentiary record. The extent to which the conclusion is based on this impermissible evidence is indeterminable.

Moreover, Dr. Hippensteel argues that any respiratory deficit was related to asthmatic bronchitis caused by cigarette smoking which is associated with his COPD. This is based, in large part on a finding of reversibility in spirometry testing. I find that this is based on a false assumption that reversibility precludes or is mutually exclusive to legal pneumoconiosis. Dr. McVey treated the miner for COPD and emphysema. In ***Hughes v. Clinchfield Coal Co***., 21 B.L.R. 1-134, 1-139 (1999), the Board held that chronic bronchitis and emphysema fall within the definition of pneumoconiosis if they are related to the claimant's coal mine employment.[8] I find that Dr. McVey's logic is more reasonable than Dr. Hippensteel's as bullous emphysema, aggravated by cigarette smoking, combined with asthmatic bronchitis is substantiated by the treatment records.[9]

Therefore, I must substantially discount the probative value of Dr. Hippensteel's medical opinion.

Dr. Ghia concluded that the miner's respiratory impairment in no way caused, aggravated, or hastened the death of the miner. Coal mine dust induced pulmonary impairments did not play any role in hastening the miner's death, even by a few days. While Dr. Ghia's review comprised admissible evidence admitted into the record, his citation to various studies in support of his position and medical opinion makes his conclusions less probative on the issue of death due to pneumoconiosis. Dr. Ghia, in his medical report, references several studies which analyze the link between cigarette smoking, coal mine dust exposure and respiratory impairments. Most of the studies see as rare, but do not completely foreclose, the possibility that coal mine dust may be attributed to significant pulmonary impairments. One study concludes that, "in the absence of cigarette smoking, long term underground coal mining does not result in significant impairment of pulmonary function."[10] This conclusion is inconsistent with and hostile to the Act. I cannot determine the extent of Dr. Ghia's reliance on this study in reaching

---

[8] I do not use this as precedent, but I note that in ***Consolidation Coal Co. v. Swiger***, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.), the court upheld the ALJ's finding that reversibility of pulmonary function values after use of a bronchodilator does not preclude the presence of disabling coal workers' pneumoconiosis.

[9] Again, I do not cite this as precedent, but even cigarette smoking can interplay with compensable pneumoconiosis. ***Consolidation Coal Co. v. Director, OWCP [Williams***], 453 F.3d 609 (4th Cir. 2006).

[10] See Rom, WM et al…, *Respiratory Disease in Utah Coal Miners*, Respiratory Disease in Utah Coal Miners, Am Rev Respir Disease 1981; 123372-377.

his conclusion. Nevertheless, I find that Dr. Ghia's reference to the study, among others he has cited, implies his adoption of the study's findings in reaching his conclusion. Dr. Ghia states that the miner's death is attributed to respiratory failure caused exclusively by cigarette smoking. I find that Dr. Ghia's conclusion is premised, at least partially, on a proposition set forth in a study that is contrary and hostile to the Act. Because the study is only one of a number of studies that is cited in support of his proposition, I do not conclude that Dr. Ghia, by implication, is hostile to the Act as well. However, I do accord little weight to the opinion of Dr. Ghia since his ultimate conclusion as to the issue of death due to pneumoconiosis is tainted by reliance on the study, however minimal.

Therefore, based on a review of the entire record, I attribute greater weight to Dr. McVey's opinion contained in the death certificate, and I find that pneumoconiosis hastened the miner's death. 20 C.F.R. §718.205(c)(5) (2001). ***Richardson,*** *supra* and ***Shuff,*** *supra (*employing "hastening" standard).

CONCLUSION

This is a survivor's claim. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP****, supra*. In order to receive benefits in a survivor's claim, the Claimant must prove: (1) that the miner had pneumoconiosis, (2) the miner's pneumoconiosis arose out of coal mine employment, and (3) the miner's death was due to pneumoconiosis. 20 C.F.R. § 718.205(a). The presence of pneumoconiosis was established in the living miner's claim. Based on the doctrine of collateral estoppel, the Claimant can bar the Employer from relitigating this issue. Upon review of all relevant evidence, I find that the Claimant has established, by a preponderance of the evidence, that the miner's death was due to pneumoconiosis because the death was hastened, "to some degree," by the miner's pneumoconiosis.

COMMENCEMENT OF THE PAYMENT OF BENEFITS

In a survivor's claim if the claimant is an eligible survivor of a miner entitled to benefits under the Act, benefits may be paid beginning with the month of the miner's death. 20 C.F.R. §725.503(c) (2000) and (2001). The miner died on March 15, 2005. Therefore, Benefits may be paid as of the month of March 2005.

REPRESENTATIVE'S FEES

Thirty days is hereby allowed to claimant's representative for the submission of an application for fees. A service sheet showing that service has been made upon all the parties, including claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application. I note that the representative in this case is not an attorney. The statute does not permit the fees of a lay representative to be shifted to an employer. ***Kuhn v. Kenley Mining Co***., Case No. 01-2255 (4th Cir. Apr. 4, 2002)(unpub.), 20 C.F.R. §725.367(a). Any fee must be paid by the Claimant.

ORDER

It is **ORDERED** that the claim of **C.Y.,** widow of **P.Y.** is **GRANTED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).